5. Physician Services

Physician Services are limited to procedures performed, or directly supervised by a practitioner licensed by the appropriate State Board of Medical Examiners as a doctor of medicine or osteopathy. Services are further limited to those rendered by an enrolled physician provider on behalf of an eligible recipient within the designated South Carolina Service Area. All services must be medically necessary and appropriate for the diagnosis and treatment of a specified condition. Physician Services may be rendered in a physician's office, clinic, hospital, nursing home, patient's home or elsewhere.

Technical Services, including materials that are supplied by a physician in an ambulatory setting are considered part of the physician's professional service unless specifically designated as a separate service in the South Carolina Medicaid Physician, Clinical and Ancillary Services Manual.

Physician supervision is restricted to services provided under the direct supervision of a physician directing a paramedical professional or other licensed individual. The physician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the patient.

Ambulatory Care Examinations:

Effective October 1, 1991 Ambulatory Care Examinations are limited to twelve (12) visits per State fiscal year (July-June) per recipient. All ambulatory care examinations prior to October 1, 1991 will not count toward the twelve (12) visit limitation. Recipients under the age of 21 years are exempt from the twelve (12) visit limitation. Ambulatory care exams include all physician office examinations for general medical diagnoses and specialty care. Included in the ambulatory care restrictions are rural health clinic encounters and initial psychiatric visits. Surgery, therapy, family planning, diagnostic tests, monitoring, and maintenance management are not included in the twelve (12) visits limitation.

Hospital Services rendered by a physician are not restricted but are subject to the pre-admission review process, medical necessity criteria and the limitations included in the hospital section of the plan.

All services listed in the Current Procedural Terminology Text (CPT), and the HCPCS Supplemental Coding Manual are allowed services unless restricted in the Medicaid Physician, Clinical and Ancillary Services Manual. These services include, but are not limited to, general medical care, diagnostic services, therapeutic services, reconstructive and medically necessary surgeries, maternal care, family planning, rehabilitative and palliative services, lab, x-ray, injectable drugs, and dispensable and supplies not restricted in other areas of the plan or the Medicaid provider manuals.

Physician Services that are specifically restricted are speech therapy. Speech and hearing examinations, physical therapy, and occupational therapy are restricted as defined in the Physician, Clinical and Ancillary Services Manual. Vision Care Services provided by a physician are restricted as defined in the Optometric section of the plan and the Vision Care Manual.

Preventive Care:

Well Baby Care is limited to routine newborn care and follow up in the hospital. All other well baby services are limited to the provisions defined in the EPSDT section of the plan.

Immunizations are limited to those defined in the EPSDT section of the plan, except for influenza, pneumonia and hepatitis vaccinations for at risk patients as described in the Physician, Clinical and Ancillary Services Manual.

Preventive Services are further limited to specific cancer screening procedures as listed for the following at risk patients without diagnostic indicators:

1. Mammography - Baseline: age 35-39, One every other year: age 40-50, One every year: age 50-up.

2. Pap Smear - One per year: age in conjunction with onset of menses.

3. Digital Rectal Exam - One per year: age 50-up for low risk clients: age 40-up for high risk clients.

4. Hemoccult Test - One per year: age 50-up for low risk clients: age 40-up for high risk clients.

5. Sigmoidoscopy - Sponsored if either test in #3 or #4 above is positive.

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TN No. NEW DATE/EFFECTIVE 12/1/88

6a. PODIATRIST. Podiatry services must conform to the guidelines and limitations as specified under Muscoluskeletal System/Podiatrv Services Section of~the Professional Services Manual.

6b. OPTOMETRIST. Vision Care services are those which are reasonable and necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable.

Covered Services:

A. Recipients 21 years of age and over, are limited to the following services:

1. Eye examinations.

2. Glasses or lenses are supplied for patients requiring cataract surgery, detached retina surgery, corneal surgery, or glaucoma surgery. Prior authorization is required for post surgical lenses for recipients age 21 and over.

B. Services for EPSDT recipients are as follows:

1. Eye examinations.
2. Glasses, if prior approved by the State Health and Human Services Finance Commission.
3. One original and one replacement or repair of the original pair of glasses per fiscal year, if prior approved by the South Carolina State Department of Health and Human Services.

Non-Covered Services:

1. Visual Therapy or training.
2. Tinted lenses.
3. Training lenses.
4. Lenses covered as a separate service (except replacements).
5. Protective lenses.
6. Oversize lenses.
7. Lenses for unaided VA less than 20/30 + or -.50 sphere.
8. Plastic lenses for prescription less than + or -4 diopters.
9. No allowable benefits for optometric hypnosis, broken appointments, or charges for special reports.

6c. CHIROPRACTORS: Chiropractic services are those which are limited to manual manipulation of the spine for the purpose of correcting subluxation demonstrated on x-ray. For the purpose of this program, subluxation means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

Chiropractic services must conform to policies, guidelines and limitations as specified in the Chiropractic Services Manual.

6d. Certified Registered Nurse Anesthetist/AA - Certified Registered Nurse Anesthetist/AA are authorized to perform anesthesia services only. The scope of their practice is limited to that which is allowed under State Law. A copy of their certification must be on file at the practice site.

Other Medical Care or Remedial Care Provided by Other Practitioners

6.d (continued)

Nurse Practitioner - Nurse Practitioners are authorized to perform certain services pertaining to their specific approved written protocols. The scope of their practice is limited to that which is allowed under State Law and as documented in written protocol between the nurse practitioners and their physician preceptors. The written protocol must be submitted to SHHSFC prior to enrollment.

Psychologists - Psychological services are covered when prescribed by an EPSDT screen and prior authorization process. Services covered include psychological testing, evaluation and therapy. Reimbursements to practitioners are restricted to psychologists that hold doctoral level diploma, and have a valid state license as a Clinical, Counseling or School Psychologist approved by the State Board of Examiners in Psychology.

Other psychological services not related to EPSDT are limited to providers employed by certified and enrolled Medicaid providers with restrictions as prescribed in the hospital, physicians, and clinic sections of the plan.

Licensed Midwife - Licensed midwives are authorized to perform midwifery services only. Their scope of practice is limited to that which is allowed under State Law as specified in the South Carolina State Register Volume 17, Issue 7, Regulation 61-24.. In addition, a signed statement from a physician, credentialed in obstetrics, who has agreed to provide medical emergency backup must be provided with each initial prenatal claim.

HOME HEALTH CARE SERVICES - Home Healthy agency visits are limited to a total of seventy-five (75) per recipient per fiscal year based on the homebound program definition of Medicare, Title XVIII, or Items 7.a through 7.d.

NON-COVERED SERVICES:

Full time nursing care
Drugs and Biologicals
Meals delivered to the home
Homemaker services
Medical social Services
Care primarily for treatment of mental disease
Separate medical rehabilitation facilities

a. NURSING SERVICES: Reimbursement will not be made for nurses assisting with activities of daily living when such services could be performed by a home health aide.

b. HOME HEALTH AIDE SERVICES: These services must be prescribed by a physician in accordance with a plan of care supervised by a registered nurse.

c. MEDICAL SUPPLIES AND EQUIPMENT: Supplies, equipment, and appliances are limited to those listed in the Durable Medical Equipment Services Provider Manual. These services require prior approval from the State Office.

d. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY AND AUDIOLOGY SERVICES. As provided by a Home Health Agency.

9. CLINIC SERVICES:

Clinic services are limited to outpatient ambulatory centers that provide medical services which include all primary, preventive, therapeutic, and rehabilitative services. Covered Clinic services include:

a. AMBULATORY SURGICAL CENTERS: Medicaid coverage is limited to medically necessary services provided by certified and licensed ambulatory surgical centers that meet the conditions for Medicare coverage as established in 42 CFR, Part 416, Subpart B, (Conditions for coverage), and as evidenced by an agreement with HCFA.

The surgical procedures covered are limited to those described under 42 CFR Part 416, Subpart B, (Scope of Benefits), and those procedures published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates.

b. END STAGE RENAL DISEASE CLINICS: Medicaid coverage includes all medically necessary treatments and services for incenter or home dialysis as described in the South Carolina Medicaid Physician and Clinical Services Manual.

Medicaid coverage is limited to services provided by licensed ESRD clinics meeting the Medicare requirements outlined in 42, CFR Part 250 and participating in Medicare as evidenced by a Medicare agreement.

c. MENTAL HEALTH CLINICS: Medicaid coverage is limited to outpatient Mental Health clinics meeting the standards as determined by the South Carolina Department of Mental Health and services as outlined in the South Carolina Mental Health and Quality Assurance Manuals.

d. COUNTY HEALTH DEPARTMENT: Medicaid coverage includes all primary, preventive, therapeutic, and rehabilitative services that are medically justified and rendered under the supervision of a physician, and a written physician protocol as described in the Physician and Clinical Services Manual and through contract with the Single State Agency.

These services include all primary diagnostic and treatment services, maternal and child health care, and family planning services as described in the Physician and Clinical Services Manual and elsewhere in the State Plan.

Coverage is limited to health clinics licensed by, or contracted with, or under the auspices of the South Carolina Department of Health and Environmental Control.

10. DENTAL SERVICES

For recipients of any age, emergency dental services are those which are necessary to repair traumatic injury, to relieve acute severe pain, to control an acute infectious process, operative procedures required to prevent pulpal death and associated imminent loss of teeth and emergency service necessary due to a catastrophic medical condition. Allowable emergency services are limited to those listed in the Dentistry Medicaid Manual.

11.a PHYSICAL AND OCCUPATIONAL THERAPY
&
11.b Physical and occupational therapy services provided by licensed practitioners are limited to therapists licensed by state law and graduated from an approved educational program and certified to practice independently. All physical and occupational therapy services rendered by certified independent therapists must be a result of an EPSDT screening evaluation, prescribed by a licensed physician (M.D.) with a prior authorized treatment plan.

Other physical and occupational therapy services not related to EPSDT are limited to providers employed by certified and enrolled Medicaid providers with restrictions as prescribed in the hospital, physician, clinic and home health sections of the Plan.

11.c Speech/Language and Audiological: services are provided by licensed or certified practitioners as certified in accordance with state law. Services covered are evaluations, speech/language therapy, audiological testing and hearing aid evaluations and orientation for EPSDT eligible recipients.

12.a PHARMACY SERVICES. Under the vendor drug program is included the dispensing of certain legend drugs and certain non-legend drugs to eligible recipients. Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication.

Only pharmaceuticals which meet Food and Drug Administration requirements and are approved for marketing may be supplied. The patient must have a valid prescription from his physician, dentist, or podiatrist.

Recipients aged 21 and older, are limited to four (4) prescriptions/ refills per month with maximum hundred (100) day supply per prescription/refill. (Certain medications may be exempted from the four (4) prescription limit.) Recipients aged birth through the month of their 21st birthday receive unlimited prescriptions/refills per month.

Long term care facility recipients whose medications are supplied by provider under the Alternate Reimbursement Methodology and specified in the provider ARM contract, will receive all drugs as necessary uner sections 1919 (b)(4)(A)(iii). Federal financial participation will only be provided for Medicaid drugs provided to long term care facility residents, from manufacturers participating in the Medicaid Drug Rebate Program.

Based on the requirements of section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), state plan amendment is revised to add the following issues concerning the Drug Rebate Agreements:

- Effective January 1, 1991 Medicaid will cover only drugs of participating manufacturers except 1-A drugs, where state process for approval must be described. (Because of extenuating circumstance waiver, states may cover non-participating manufacturers' drugs for claims with date of service through March 31, 1991.)
- A formulary or other restrictions must permit coverage of participating manufacturers' drugs.
- The state will comply with the reporting requirements for state utilization information and on restrictions to coverage.
- If state has "existing" agreements, these will operate in conformance with law, and for new agreements, require HCFA approval. State must also agree to report rebates from separate agreements.
- A state must allow manufacturers to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verifications.

- Prior authorization programs must provide for a 24 hour turnaround on prior authorization from receipt of request and at least 72 hour supply in emergency situations (effective July 1, 1991).

- States must cover new drugs of participating manufacturers (except excludable/restrictable drugs) for 6 months after FDA approval and upon notification by the manufacturer of a new drug. The state may put the drug through its formulary but it cannot prior authorize the new drug and, consistent with the second item above, it must cover drug (again with the exception of excludable/restrictable drugs). The state plan must list the classes chosen for exclusion/ restriction or if less than the full class, list the drugs within the class chosen for exclusion/restriction.

- The state may make no payment for innovator multiple source drugs when a less expensive noninnovator multiple source drug is available (effective July 1, 1991).

- The state may not reduce its limits on covered outpatient drugs or dispensing fees effective January 1, 1991 unless it was out of compliance with Federal requirements on November 5, 1990.

- State plan must have been submitted by March 31, 1991 to be effective January 1, 1991. However, because HCFA invoked the extenuating circumstances clause in the law, drugs were payable in the first quarter without losing FFP, even if the plan was not submitted by March 31, 1991.

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SUPERSEDES: N/A

GENERAL EXCLUSIONS: As provided by Section 1927(d) of the Social Security Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

A. Medications used for weight control.
B. Pharmaceuticals deemed less than effective by the Drug Efficacy Study Implementation (DESI) Program.
C. Over-the-counter (OTC) pharmaceuticals except for those listed in the Pharmaceutical Services Provider Manual, Chapter 200.
D. Topical forms of minoxidil when used for hair loss.
E. Agents when used to promote fertility. (Effective March 1, 1991)
F. Agents when used to promote smoking cessation. (Effective March 1, 1991)

As provided by Section 1927(k) (2) of the Social Security Act, certain other exclusions are:

G. Investigational/experimental pharmaceuticals or products without FDA approval under the Federal Food, Drug, and Cosmetic Act.

As provided by Section 1927(k) (3) of the Social Security Act, certain other exclusions are:

H. Injectable table pharmaceuticals administered by the physician in his office, in a clinic or in a mental health center.

Drug Prior Authorizations can be requested by the prescribing physician or pharmacist with needed documentation for items excluded from coverage and those drugs requiring special authorization as outlined in the Pharmaceutical Services Medicaid Manual, except those drugs ruled ineffective (DESI) by the Federal Government.

12c. PROSTHETIC OR ORTHOTIC APPLIANCES. Approval from the State Office is required prior to the provision of the prosthetic or orthotic appliance. Supplies, equipment, and appliance limitations are specified in the Durable Medical Equipment Provider Manual, and follow Medicare limitations.

12d. EYEGLASSES OR CONTACT LENS FOR RECIPIENT OVER AGE 21. Glasses or lens are supplied for patients requiring cataract surgery, detached retina surgery, corneal surgery, or glaucoma surgery. Prior Authorization is required for post surgical lenses or recipients age 21 and over.

13c. PREVENTIVE SERVICE FOR PRIMARY CARE ENHANCEMENT

A. Definition of Service - Preventive Services for Primary Care Enhancement (PSPCE) are services, including assessment and evaluation, furnished by physicians or other licensed practitioners of the healing arts acting within the scope of practice under State law which are furnished in order to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

Covered PSPCE must either be: (1) required for the development and implementation of a comprehensive medical plan of care by a physician and other appropriate practitioners, or; (2) medically necessary preventive services identified in the comprehensive PSPCE medical plan which are not otherwise covered under the State plan.

B. PSPCE Plan of Care Requirement - The PSPCE medical plan of care must be designed to enhance the individual's practice of healthy behaviors, prevent deterioration of chronic conditions, and promote the full and appropriate use of primary medical care. A PSPCE medical plan of care must be developed with the following components:

- assessment/evaluation of health status, individual's needs, knowledge level;
- identification of relevant risk factors or needs which justify the medical necessity for PSPCE;
- development of a goal-oriented plan of care (in conjunction with the physician and individual) that addresses risk factors and needs identified in the assessment/evaluation, and which specifies the service(s) necessary to reduce/ameliorate the risk factor(s);
- anticipatory guidance/counseling to limit the development/progression of a disease/condition and to achieve the goals in the medical plan of care.

C. Medical Necessity Criteria for PSPCE Preventive Services - The PSPCE medical plan of care must include findings that preventive services covered as PSPCE are medically necessary due to:

- high risk for developing a disease or experiencing a negative health outcome; or
- mental/physical impairments which result in risk of poor adherence to a plan of care or need for reinforcement to enhance likelihood of full and appropriate use of primary care; or
- need for effective management of a recently diagnosed disease, when such management could prevent further progression of the disease.

D. Special Conditions - In order to be covered as PSPCE, preventive services must: (1) be included in the PSPCE medical plan of care; (2) involve direct, one-on-one individual contact; and (3) be medically-oriented. Group sessions that allow direct one-on-one interaction between the counselor and the individual may also be used to provide some components of this service.

E. Qualification of Providers - Providers of PSPCE are physicians or other practitioners of the healing arts licensed by the State and acting within the scope of their practice under State law (e.g., nurse practitioners, registered dieticians, registered nurses, licensed master social workers, licensed baccalaureate social workers, licensed practical nurses).